Correspondence

The Acquired Immunodeficiency Syndrome in Older Persons

TO THE EDITOR: Since it was first reported 13 years ago, the acquired immunodeficiency syndrome (AIDS) has emerged as a leading cause of death in young and middle-aged persons. This has led to the mistaken impression among some health care professionals and the general public that AIDS is not a health issue for older persons when, in fact, it is being increasingly diagnosed in persons older than 50 years.[1,2]

During the first decade of the human immunodeficiency virus (HIV) epidemic in the United States, about 10% of AIDS cases were in persons 50 years of age or older, accounting for more than 20,000 cases to date. After 1989, about 30% of older persons diagnosed with AIDS have been older than 60, and relatively more of these cases have been among women and whites.

The relative distribution of risk factors for acquiring HIV disease is different for older persons. Homosexuality and injection drug use account for 90% of cases of AIDS in persons 13 to 49 years old, but these have been the primary risk factors in only 20% of cases in persons older than 70.[1] In older persons, transfusion with blood or blood products has been the most frequent means of being infected with HIV. Although the risk of acquiring HIV infection from transfusions diminished after widespread blood screening for the virus was implemented in 1985, a small but finite risk—estimated to be 1 in 250,000 units in 1993—still exists.[1,3]

Of Americans older than 50 years, 10% report at least one risk factor for HIV infection. The most common are a history of multiple sexual partners, sexual encounters with high-risk partners, especially for the estimated 1 million homosexuals older than 65, and a history of transfusion. Of AIDS cases among older persons, 10% are attributed to heterosexual transmission, which is the highest percentage in any age group. This rate seems to be increasing.

Many older persons with HIV infection resulting directly or indirectly from blood transfusion have not been tested and do not know of their potential infectivity. Among older persons with at least one risk factor for HIV, 90% have not undergone serologic testing.[4] When controlled for other demographic variables, the population of older persons with risk factors for HIV is a fifth as likely to undergo HIV testing as persons 20 to 29 years of age. In view of this relative paucity of testing in older persons, it should not be surprising that older people use condoms much less frequently—reported to be a sixth that of persons aged 20 to 29 years.[4] This is ironic because older gay and bisexual persons have been reported to be more compliant in practicing safe sex than younger at-risk persons.

The clinical presentation of AIDS-HIV disease in older persons is different.[1,2,5] Published reports support the clinical impression that HIV disease progresses more rapidly in older persons—both from asymptomatic infection to overt immunocompromise and from full-blown AIDS to death. The number of cases of AIDS diagnosed in the same month as death occurs increases with age and is most pronounced in persons older than 70.[1] A contributing factor is a delay in diagnosis, which may result from a low index of suspicion of HIV infection by both patients and their physicians, as well as the increased frequency with which nonspecific signs such as weight loss, fatigue, and deteriorating mental and physical function herald the onset of disease in older persons.[1,3] Although *Pneumocystis carinii* pneumonia is the most common opportunistic infection seen in HIV-infected adults, AIDS-related dementia or encephalopathy is commonly a first sign of the disease in the elderly.

Physicians should recognize that sex occurs among their older patients and discuss safe sexual practices with them. Older patients may be more reluctant to volunteer this information, so clinicians need to be adept at soliciting it. They also must be attuned to relevant nuances in the prevention message, such as the older woman's potentially increased risk of age-related vaginal trauma and, therefore, transmission by heterosexual contact.

Recognizing risk factors and early signs of HIV disease in older persons presents special challenges to clinicians, but is critical to preventing the spread of the disease and to delaying secondary complications in seropositive patients. Clinicians also need to be aware of potential side effects of drugs, iatrogenic complications, and the need to tailor treatment for older AIDS patients. This will be challenging as AIDS care is increasingly provided in outpatient and community-based settings.

CHRISTINE P. ROZANCE, MD
KENNETH W. KIZER, MD, MPH
Dept of Community and International Health
University of California, Davis, School of Medicine
Davis, CA 95616

REFERENCES

1. Wallace JI, Paauw DS, Spach DH: HIV infection in older patients: When to suspect the unexpected. Geriatrics 1993; 48:61-64, 69-70
2. McCormick WC, Wood RW: Clinical decisions in the care of elderly persons with AIDS. J Am Geriatr Soc 1992; 40:917-921
3. Boudes P: HIV infection in the elderly. Compr Ther 1992; 17:39-42
4. Stall S, Catania J: AIDS risk behaviors among late middle-aged and elderly Americans. Arch Intern Med 1994; 154:57-63
5. Ferro S, Salit IE: HIV infection in patients over 55 years of age. J Acquir Immune Defic Syndr 1992; 5:348-353

A Patient's Choice?

TO THE EDITOR: The "Lessons From the Practice" by Theodore Schwartz, MD, in the July issue[1] was touching and humbling. I think it particularly notable that the event took place in the mid-1960s. If this episode were to take place in the 1990s, the story would have ended differently—probably in front of a jury. Nowadays, physicians are damned if they do *not*—inform, caution, warn, educate exhaustively, and record it—or damned if they do all of these. I say "damned if they do" because the written,